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ABSTRACT

The manual is intended for use in training institutes for persons providing respite care for families of children with developmental disabilities in Montana. Expectations for participants and objectives for training are outlined in preliminary sections. Each chapter contains a brief statement of the chapter's main point or points, a selected bibliography, and a discussion. Topics covered include normalization, the developmental approach, basic rights of the disabled, nature of developmental disabilites, language and communication, behavior management, basic needs of the disabled child, programing activities, and general medical problems. Also include throughout the manual are instructions for lifting and carrying the child; suggested methods of dressing and undressing, special adaptations for the blind; suggested recordkeeping form; a seizure report; a medication administration record; and a medication glossary including common abbreviations used in administration of medications. A brief description of the Developmental Disabilities Training Institute concludes the manual. (DB)

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RESPITE CARE

TRAINING MANUAL

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DEVELOPMENTAL DISABILITIES
TRAINING INSTITUTE

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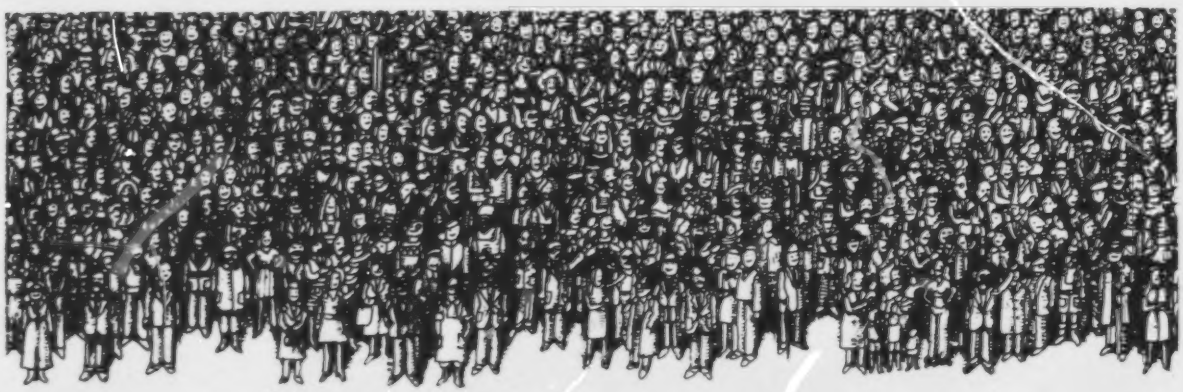


Welcome to the Developmental Disabilities Training Institute Respite Care Providers training session!

Respite Care is an exciting and demanding concept which is essential to the development and maintenance of sound community-based programs. For years one of the most confounding problems that the parents of a developmentally disabled child faced was the lack of relief provided by qualified personnel. Parents of developmentally disabled people, like other parents, need time away from family responsibilities to pursue outside interests. Conventional "baby-sitting" services have not been able to meet the needs and special demands of developmentally disabled persons and their families.

This training session is designed as the first step in introducing you to what those needs may be and how you can effectively provide for them. You will receive basic background information and a beginning set of skills which should serve as the basis for your developing expertise as a respite care provider. As a respite care provider you may have the exciting opportunity to provide services for a wide range of developmentally disabled individuals. It is impractical for a training session of this length to deal with all individual specifics you may encounter. However, this session will provide you a basic problem-solving approach and the procedures for working with the developmentally disabled person's (and his/her family's) needs. It will be up to you to increase your skills and expertise on specific topics. If you desire more information or training, the Developmental Disabilities Training Institute (DDTI) will assist and support in these efforts by providing both additional materials and training.

This manual is designed as a support to the total respite care training package of DDTI. It is hoped that you will find it to be a valuable resource for clarification of presentations during training as well as a useful reference as you provide respite care.

EXPECTATIONS FOR PARTICIPANTS

1. Goal of Training

   a. to provide you with information, a set of experiences, and a set of procedures to equip you as a respite care provider.

2. Format of Training

   a. This training session will include both large group presentations of orientation and background information as well as small group participation. Time will be allowed for you to meet and interact with parents and potential clients of respite care services.

   b. The training session will be competency based and is therefore an individualized program.

      1. After each module is presented, a criterion check will be given. The purpose is to help you assess how well you as an individual are handling the information, not to evaluate you as compared to another participant. It is necessary that you achieve at least 80% on each criterion check.

      2. Time will be alloted for questions, discussion, and individual feedback.

      3. The training session is designed to provide you with a rationale for what you are doing and why you are doing it. You are not expected to have all the answers, but you will be expected to be able to get them, e.g., Developmental Disabilities Training Institute (DDTI) will be available for further information or training.

         DDTI
         508 Power Block
         Helena, MT 59601 phone 443-4650

      4. The training schedule is attached.

      5. Some cautions:

         a. Don't be afraid to make mistakes--that's how one learns.
         b. Don't be afraid to ask questions.
         c. Don't make promises you can't fulfill.

Training Objectives

As stated in the Expectations for Participants, the goal of this training session is "to provide you with information, a set of experiences, and a set of procedures to equip you as a competent respite care provider."

In meeting this goal, several objectives (or steps) have been identified. These objectives are listed on the following pages. It is important for you and us to measure how well you have mastered the information in each objective. It is equally important for us to measure how well we have presented it. Therefore, criterion checks and feedback forms will be filled out on each presentation.

Please review the following objectives in preparation for meeting the goal of this training.

Upon completion of the following modules, each participant will be able to do the following:

Normalization, Developmental Approach, Basic Rights
To define the concepts of normalization, developmental approach, basic rights, (including least restrictive alternative).

Orientation to Developmental Disabilities
To define the handicapping conditions included under the term, developmental disabilities.

Providing Respite Care
To define respite care.

Language and Communication
To define communication.

To describe three types of communication.

To describe the importance of talking to a developmentally disabled person, regardless of the degree of handicapping condition.

Behavior Management
To briefly describe the principles associated with behavior management,
positive reinforcement,
extinction,
punishment.

Training Objectives (cont'd)

Meeting Basic Needs

To describe why the developmental model serves as a guideline for people assisting developmentally disabled individuals take care of their basic needs.

To describe and demonstrate procedures and behaviors which are important when assisting a developmentally disabled individual with dressing, bathing, eating, and moving from one place to another.

Programming Activities

To demonstrate interaction skills with developmentally disabled individuals.

General Medical Problems

To describe the procedures for treatment of common household injuries.

To list the five rights of medication.

NORMALIZATION

chapter 1

Normalization is a decision-making process which allows and encourages a developmentally disabled individual to achieve to his/her maximum potential in cooperation with other community members.

Selected Bibliography

Blatt, B. and Kaplan, F. Christmas in Purgatory, A Photographic Essay on Mental Retardation. Allyn and Bacon, Boston, Massachusetts, 1966.

Cherington, Carolyn and Gunnar Dybwad, eds. New Neighbors, The Retarded Citizen in Quest of a Home. President's Committee on Mental Retardation, Washington, D.C., 1974.

Edgerton, R.B. The Cloak of Competence: Stigma in the Lives of the Mentally Retarded. University of California Press, Berkeley, 1967.

"Like Other People". Perennial Education, Inc. P.O. Box 236, 1825 Willow Road, Northfield, Illinois.

Wolfensberger, W., Kugel, R., eds. Changing Patterns in Residential Services for the Mentally Retarded. Washington: U.S. Government Printing Office, 1969.

Wolfensberger, W. The Principle of Normalization in Human Services. Toronto: National Institute on Mental Retardation, 1972.

Background:

Community-based services for the developmentally disabled, both nationwide and in Montana, are just beginning to evolve. Services like respite care, group homes, day activity centers and integrated school programs were not in existence a short time ago. In order to support the growth and development of these community-based services in this state, Montanans have chosen a strong philosophical base --- Normalization.

The principle of normalization grew out of work with the mentally retarded citizens in Scandinavian countries during the 1960's. Nirje (1969) and Wolfensberger (1972), along with others, have been instrumental in bringing this principle to the attention of human service workers in this country. The recognition of the realities of this principle by a large cross-section of persons working in the field of developmental disabilities has resulted in the movement away from centralized treatment facilities and towards the development of individualized community-based services for all developmentally disabled persons.

Application:

According to Bengt Nirje, ". . . the normalization principle means making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society" (1969, p. 181). In simpler terms, normalization can be defined as a decision-making process which allows and encourages a developmentally disabled person to achieve his or her maximum potential in cooperation with other community members.

This definition seems to many people to be common sense, and many wonder why it is necessary to take time to dwell upon something which is so obvious. Unfortunately, the very basics of the "all-American dream" of encouraging persons to become the best they possibly can by providing opportunities for growth and development has been denied to developmentally disabled individuals in the past. Traditionally, we have isolated these persons in large centralized institutions or failed to provide opportunities to participate in a variety of necessary learning experiences. It was easy to rationalize our actions by saying that developmentally disabled persons would be unable to benefit from such opportunities.

On the other hand, by applying the normalization principle on a daily basis and assisting individuals in experiencing a more normal routine of life, we are changing considerably our views on what the developmentally disabled can do. Instead of isolation and segregation of the developmentally disabled, we are now encouraging the opportunity for these individuals to be assimilated into the community patterns and to contribute to community activities to the greatest extent possible.

We are now stating that the developmentally disabled need to experience typical life patterns of a community. They need to participate in a typical routine of the day, not isolated in one building or home, but involved in activities in different physical settings. For many in the past, the entire

day consisted of moving from a bed to a mat in the day room, never leaving the building and essentially never getting out of bed. Services such as preschools, day care centers, school programs, day activity programs and sheltered workshops have given developmentally disabled persons in the community the opportunity to leave the home or residential facility. There they work and/or learn in much the same manner as we have experienced throughout our lives. Not only do these services provide the clients with an opportunity to participate in activities in a new environment, but they also encourage growth and development. These experiences assist the individual in becoming increasingly more and more productive in that community setting. Thus, the normalization principle implies a normal routine of life avoiding routinization caused by lack of staff or facilities. This includes a normal rhythm of the year with holidays, vacation time, and family days of personal significance.

A key concern in applying the normalization principle is the assurance that developmentally disabled persons undergo normal developmental experiences of the life cycle. Consider what activities are necessary for children, adolescents, adults and the aged to fulfill their basic needs. These activities should be provided in a manner which is age appropriate.

Normalization implies that we live in a world of two sexes. It is only by experiencing relationships with members of the same and the opposite sex that appropriate social roles or repertoires of behaviors are developed. Some of our greatest fears of sexual deviance in the developmentally disabled have actually been encouraged by not allowing typical opportunities for interactions with members of the opposite sex.

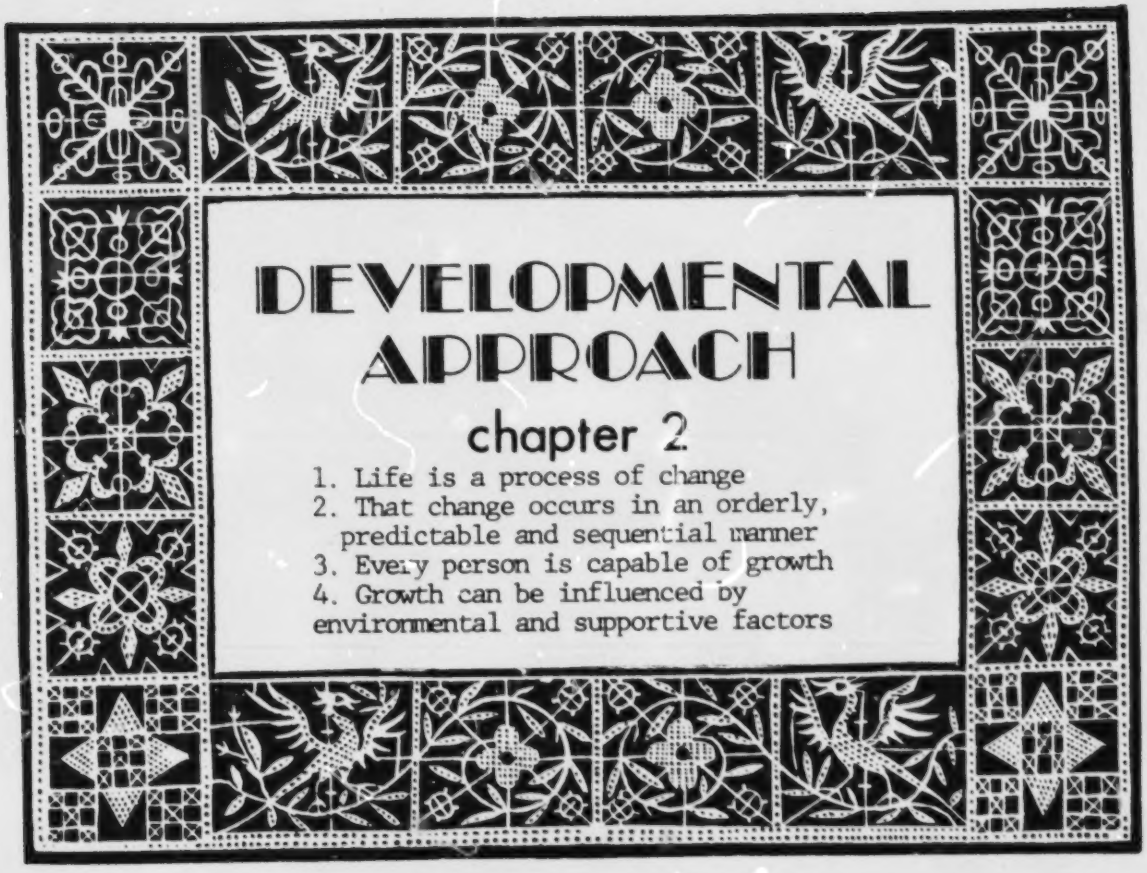
Developmentally disabled individuals have also been denied the right to choose in the past. Normalization insures that choices that we make daily and take for granted are provided to developmentally disabled individuals. Even the simplest matters such as what to have for lunch or what to do with your days off have been arbitrarily denied to people whose ability to make such choices has been questioned. It is not until one has experienced a wide range of options that interests and preferences begin to develop. These experiences, in turn, guide many of our later decisions. The right to choose includes the dignity of being allowed to make mistakes and profit from them as learning experiences.

Normalization means that you, as respite care providers, should encourage your clients to grow through experience. This is not to say that you should take the client horse-back riding if the parent has asked you to remain in the house. It does mean that you should provide a stimulating experience. Even seeing a new face and getting to know a new person with likes, dislikes, habits and quirks is, in and of itself, a learning experience. Providing the opportunity for a client to interact with you as a respite care provider is an extremely valuable experience. Change often takes time; attitudes of the community, your friends, the client's family and even yourself should not limit the developmentally disabled individual. If we use the concept of normalization as a programming guideline, all of us, especially the client, will benefit.

References:

Nirje, B. The normalization principle and its human management implications. R. Kugel and W. Wolfensberger (Eds.) Changing Patterns of Residential Services for the Mentally Retarded. Washington: President's Committee on Mental Retardation, 1969.

Wolfensberger, W. The Principle of Normalization in Human Services. Toronto: National Institute on Mental Retardation, 1972.


DEVELOPMENTAL
APPROACH
chapter 2
1. Life is a process of change
2. That change occurs in an orderly, predictable and sequential manner
3. Every person is capable of growth
4. Growth can be influenced by environmental and supportive factors

Selected Bibliography

ACFMR. Standards for Residential Facilities for the Mentally Retarded. Chicago: Accreditation Council for Facilities for the Mentally Retarded, 1971.

"Larry". Learning Corporation of America, 1350 Avenue of the Americas, New York, New York 10019

NARC. Residential Programming for Mentally Retarded Persons: A Developmental Model for Residential Services. Arlington, Texas, National Association for Retarded Citizens, 1972.

Roos, P., Patterson, G., and McCann, B. Expanding the Developmental Model (an unpublished paper). Arlington, Texas: National Association for Retarded Citizens, 1970.

Just as the normalization principle provides guidelines for providing services to developmentally disabled persons, so too does the developmental approach. The basic premise of a developmental approach states that the types and ranges of services which a client needs today will change as that client's needs change. Community services, including respite care, must have the flexibility to meet the ever-changing needs of the individuals whom they serve. With the implementation of services which use the developmental approach as a guideline for programming, it will no longer be necessary to mold the client to fit within the boundaries of the service, but rather it will be possible to mold the service to fit the needs of the client.

The first premise of the developmental approach is that life is a process of change. All persons change daily from infants to young children to adolescents to adults and, finally, to aged individuals. As persons grow, develop and mature, their needs change. Much of the individual's ability to respond to this change relates to the experiential opportunities encountered in day-to-day living. This is easy to realize when we consider that none of us (including the handicapped) are the same person we were a year, a month, a week ago, or even yesterday. In the past, we have often put a ceiling on our expectations for developmentally disabled individuals. The result has been a response to the label "handicapped" rather than the fact that each person is continually developing. It is the responsibility of the respite care provider to insure opportunities for learning are provided according to the changing needs of his/her client.

The second assumption is that human growth and development is orderly, sequential and predictable. This statement holds true in all facets of the learning process. In physical development, for instance, one scoots before he/she crawls, and crawls before he/she walks. The same is true in language development; there is a definite sequence of approximations which eventually turns into that magic first word. It is useful to identify at what stage of development an individual is in any given learning process. Such estimates make it easier for the respite care provider to set up meaningful learning opportunities which will support progress toward the next step.

The third belief of the developmental approach is that all persons have the capacity for growth. This is an obvious statement but has been often overlooked. Regardless of the disabling condition that an individual has, every individual can learn new skills and behaviors which will make them more and more capable. What does vary among individuals, whether they are developmentally disabled or not, is that all individuals grow and learn at different rates. For some developmentally disabled individuals, the rate of growth may be slower. In these cases, more trials are needed to learn specific skills. We all have areas in which we learn and process information more slowly than others; this is also true for the developmentally disabled individuals. Therefore, as a respite care provider, you should assume that any client you are working with can grow. The rate of growth, however, may vary in certain areas.

The fourth, and perhaps most significant, implication of the developmental approach is that the rate and direction of growth can be influenced by environmental and supportive factors. This can be demonstrated rather graphically by

taking a look at a common household plant. If we are aware of what that plant's needs are and can provide them in the correct amount and at the right time, we will have a beautiful flower to enjoy throughout the years. On the other hand, if the plant is deprived of the sunlight, water and food that it needs, the rate of development will be slow indeed. Although the needs of humans are incredibly more complex than those simple elements necessary to support plant growth, what does remain the same is that, if we can provide the support any individual needs in the correct amounts and at the correct times, they will grow and develop more rapidly. By providing services as a respite care worker, you will be helping the parents maintain their son or daughter in their own home. In this environment, the supports are available which can influence the rate and direction of their son or daughter's growth.

Implicit in the developmental model is the fact that we need to encourage growth and maturation throughout anyone's life. It is no longer correct for us to hold a retarded or otherwise disabled individual at the level of a child or adolescent. This is an important consideration for your interaction with individuals of a variety of ages; obviously you would not treat a 20 year old client in the same way as you would interact with a young child. Therefore, along with the concept of normalization, the developmental approach can serve as an important guideline when providing services to developmentally disabled individuals.

BASIC RIGHTS

CHAPTER 3

Developmentally disabled citizens of Montana have all rights guaranteed under:

(A) The Mental Commitment and Treatment Act
(B) Other laws of Montana
(C) The Constitution of Montana
(D) The Constitution of the United States

(Revised Codes of Montana, Title 38-1304)

Selected Bibliography

Amicus. a bi-monthly publication of the National Center for Law and the Handicapped, Inc., 1235 North Eddy Street, South Bend, IA 46617.

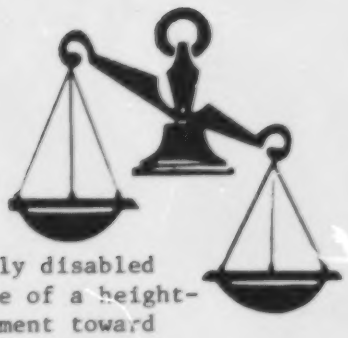
Kindred, M., Cohen, J., Penrod, D., and Shaffer, T. The Mentally Retarded Citizen and the Law. New York: The Free Press, 1976.

Law and Behavior. a quarterly publication of the Project on Law and Behavior, Research Press, 2612 N. Mattis Ave., Champaign, IL 61820.

Mental Disability Law Reporter, The. a bi-monthly publication of the American Bar Association, Commission on the Mentally Disabled, 1800 M Street, N.W., Washington, D. C. 20036.

"People First," a 16 mm film by The Stanfield House, 900 Euclid, Santa Monica, CA 90403

"Something Shared," a 16 mm film by The National Association for Retarded Citizens, P.O. Box 6109, Arlington, TX 76011.



One of the major reasons that services for developmentally disabled individuals are becoming available in the community is because of a heightened interest in the rights of all minority groups. The movement toward insuring the basic rights of developmentally disabled citizens has been accelerating since the beginning of this decade and follows the civil rights movement of the 1960's. Rights which were once indiscriminately ignored or denied in institutions and in the community are being restored through the use of the courts and redefined through the passage of specific federal and state legislation.

The historical social perceptions toward the developmentally disabled were based on the idea that it was in the best interest of the individual and the general community for the handicapped to be removed from the responsibilities of citizenship. The effects of adopting that idea resulted in a denial of the most basic human rights of millions of people. Inhumane treatment and social injustices were condoned or ignored by a majority of the professionals who, along with members of the general community, were caught-up in an attitude that the developmentally disabled were unaware of their plight or that nothing else could be done.

Something is being done, and you as a respite provider are part of that something. Many courts and legislatures have mandated that services be made available to the developmentally disabled in the least restrictive environment. Respite care in the community allows individuals to receive services without having to be placed in a more restrictive environment, such as a state institution. Living in a group home rather than a nursing home could be another example of a less restrictive environment.

One of the landmark decisions which has influenced Montana law is that of Wyatt vs. Stickney. This 1970 class action suite was filed in Federal District Court in Alabama. Wyatt was a resident in a state institution for the mentally retarded and Stickney was the superintendent of the institution. Wyatt won his argument that persons involuntarily committed to an institution have a constitutional right to habilitation and treatment. This was also the first case which addressed the least restrictive alternative issue. Least restrictive alternative can be defined as the curtailment of individual freedoms to no greater extent than essential for securing progress toward the goal of habilitation. In other words, no person can be maintained in one environment when another environment is or can be made available which will help a person grow and develop to a greater extent.

For many individuals the natural home is clearly the "least restrictive alternative" possible. This, of course, depends on the individual's stage of life and personal preferences. It is in this manner that you, as a respite care provider, are a vital link in the process of providing habilitation to a developmentally disabled individual. By helping to support the individual in the natural home in a community setting, you are insuring that the

individual will not be committed to an institution where the basic rights may not be upheld. Not only does this decision imply that services must be developed to maintain those individuals who are currently in the community, but that services must be developed which will support the movement of those persons currently confined in an institution back into the community setting.

In Montana, the two most important measures which have been taken to help insure that community services are available to the developmentally disabled population of the state are House Bill 353 (now part of Montana administrative code) enacted by the legislature in 1974, and a ruling by the Montana Supreme Court on that law. H.B. 353 was an attempt to provide all major services that have been identified as necessary for the habilitation and support of the developmentally disabled in the community. Specific areas of need and concern were listed, although it is clearly stated that the services are not limited exclusively to these areas. Among other things, H.B. 353 also provides for the organization of Regional Councils to advise the state as to what the pressing and pending needs for specific communities might be. This bill seems to be an effective and oepn-ended piece of legislation which will support the development and maintenance of sound community services.

Another important decision regarding the development of community-based programs for the developmentally disabled was handed down by the Supreme Court of Montana in December of 1975. In Thelan vs. City of Missoula, the city had prohibited the Thelen's from selling their home which was zoned according to the city codes as R1 to a non-profit board who intended to utilize the facility for a group home for eight mentally retarded adults. In an opinion issued by Justice John C. Harrison, and concurred with by Chief Justice James L. Harrison and Justices Daly and Castles, it was stated that "we uphold the legislative acts providing for community residential facilities for developmentally disabled in all residential zones, including, but not limited to, residential zones for one-family dwellings." This decision made a greater number of homes available to developmentally disabled individuals in all communities throughout the state.

Important to those families of younger children and adolescents is the right to an education. In this area the decisions which have been the most important are those of the Pennsylvania Association of Retarded Children vs. Commonwealth of Pennsylvania and the Mills vs. Board of Education of the District of Columbia. In the PARC suit, the right to an education for all children, regardless of abilities, was established. The Mills case expanded that right by stating that all children should be provided with a publicly supported education. As Judge Waddy stated in this case, "If sufficient funds are not available to finance all of the services and programs that are needed in the system, then the available funds must be expended in such a manner that no child is entirely excluded from a publicly supported education consistent with his needs and abilitity to benefit therefrom." In Montana, the 1977 legislature has mandated the reality of a public education for all by September of 1977.

In conclusion, perhaps all of the legislation and litigation can be summed-up by taking a look at the founding document of our nation. These words are taken from the Declaration of Independence: "We hold these truths to be self evident, that all men are created equal." Two hundred years later we are only beginning to make that premise a reality for all people: blacks, chicanos, women and handicapped individuals. You, as a respite care provider, are an important instrument of that process.

ORIENTATION TO DEVELOPMENTAL DISABILITIES

CHAPTER 4

Developmental Disabilities is an umbrella term which is used to refer to four major handicapping conditions: Mental Retardation, Cerebral Palsy, Epilepsy, and Autism.

Selected Bibliography

Corbett, J. A., Harris, R., and Robinson, R. G. "Epilepsy," in Wortis, J. (Ed.). Mental Retardation and Developmental Disabilities VII. New York: Brunner/Mazel, 1975.

Farber, B. Mental Retardation: Its Social Context and Social Consequences. Boston: Houghton Mifflin, 1968.

"Fitting In." University of Wisconsin, Madison, Wisconsin.

Kugelmass, I. N. The Autistic Child. Springfield, Ill: Charles C. Thomas, 1970.

Molnar, G. E. and Taft, L. T. "Cerebral Palsy," in Wortis, J. (Ed.). Mental Retardation and Developmental Disabilities V. New York: Brunner/Mazel, 1973.

What Are Developmental Disabilities? DHEW Publication No. (OHD)76-29002.

Developmental Disabilities means disabilities attributable to: mental retardation, cerebral palsy, epilepsy, autism or any other neurological handicapping conditions closely related to mental retardation and requiring treatment similar to that required by mentally retarded individuals; if the disability originated before the person reaches age 18; has continued or can be expected to continue indefinitely and constitutes a substantial handicap of the person.

Montana H.B. 772, 1977

The term developmental disabilities has grown out of a national effort to insure that quality services are locally available to individuals who are mentally retarded, cerebral palsied, epileptic or autistic. These four primary handicapping conditions have been included in federal and state legislation establishing a wide array of services to be provided at the state and local level. With the passage of the Developmentally Disabled Assistance and Bill of Rights Act in 1970, the federal government launched a major effort to assist handicapped individuals in the achievement of meaningful programs designed to bring about fuller habilitation.

The earlier chapters of this reference manual have described some of the basic changes which have occured in the field of developmental disabilities over the last decade. These changes in attitudes and practices of professionals and members of the general community have underscored the fact that a handicapped person is first and foremost a developing person with needs, interests, and expectations similar to those of non-handicapped persons. The differences which exist among the developmentally disabled, as a group, make it especially critical for you as a respite provider to have a basic knowledge of the four handicapping conditions. Each of the handicapping conditions described below may be caused by a variety of factors including problems during pregnancy, complications during delivery, or injury or sickness during childhood. The effects on individual development may be minimal for one person and very severe for another. It is important to remember that over 90% of the people with a developmental disability are only mildly or moderately delayed in some areas of development. A relatively small number of developmentally disabled persons require extensive assistance in personal care and support services.

MENTAL RETARDATION

The American Association on Mental Deficiency defines mental retardation as "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period." This formal definition is widely accepted as a means

of identifying and distinguishing one handicapping condition which involves about 6 million people in the United States.

Social and environmental factors are associated with approximately 80% of mental retardation, with the remaining 20% associated with biomedical factors. Poverty and associated conditions account for more retardation than genetics, viruses, and injury put together.

While it is true that cures have been found for some diseases which can cause mental retardation, mental retardation is not a disease. Thus, mental retardation can not be cured in a typical sense, but the effects of limited intellectual functioning and undeveloped personal and social behavior can be changed through specialized education and training programs. In addition, we can work to prevent the conditions from occuring which cause mental retardation.

Four levels of retardation have been used to describe the current level of functioning in a mentally retarded person. These levels are compared to the normal or typical level of functioning of other members of the community. Mild retardation is not readily recognized except in situations where intellectual ability is a primary concern. Mildly retarded persons usually lose the label "retarded," which they acquired during their school years, upon reaching adulthood. As adults they often marry, hold jobs in the community and raise their families with minimal outside support.

The moderately retarded are able to take care of most of their affairs with support provided by other family members or human service agencies. The learning of new skills and the opportunity for participation in education and training programs will allow many moderately retarded children to develop their abilities as contributing members of the community.

The severely and profoundly mentally retarded are more dependent on others for their basic needs. The effects of their mental retardation are much greater across all areas of development, as compared with the mildly or moderately retarded. Disabilities in communication, bodily movement and personal care require specialized training programs designed to teach one specific skill at a time. The need for medical care and frequent supervision is a major factor in providing services for the profoundly retarded.

CEREBRAL PALSY

Cerebral Palsy is a lack of control over muscles in the body. The smooth flow of impulses from the brain to the muscle system is impaired. Cerebral Palsy is not a disease and, depending on the area and degree to which the brain is affected, a variety of physical handicaps will result. Damage to cerebral or brain tissue may occur as a result of disease or injury prior to birth, at birth or during childhood. Intellectual handicaps may be noted as a result of learning impaired by the motor disability.

The difficulty in using the muscles in a controlled and coordinated manner are described in the following three types of Cerebral Palsy.

Spastic Cerebral Palsy, the most common, is characterized by a stiff and jerky motion. Muscle tone is such that an initial resistance to movement gives way in a rapid decrease in resistance. In some individuals this stiffness may be barely noticeable, i.e., a slight limp. For others, their walk may resemble a sissored walk, with one leg crossing out ahead and then the other. Aids to help control for a coordinated motion include walkers, braces, adaptive tableware, etc.

Athetoid Cerebral Palsy is characterized by random movement which is involuntary. Hands, feet, as well as the face and tongue, are visably involved. The signals from the brain do not activate selected muscles in a controlled fashion, but instead activate the surrounding muscles as well. The purposefulness of movement is very difficult to maintain. Attempts to pick up objects, for example, involve many large and small muscles which interfere with the pinching motion of thumb and forefinger.

Ataxic Cerebral Palsy is characterized by an inability to maintain normal balance and depth perception. The difficulties in balance and perception keep the body in a state of disorientation when attempting motor skills.

Each of the types of Cerebral Palsy may exist independently or may be mixed in certain individuals.

EPILEPSY

Epilepsy is nearly synonomous with seizures, yet some epileptics who experience seizure activity during childhood are nearly free of seizure activities during adulthood. Sudden electrical impulses discharged by the brain result in seizures sending the body into convulsions. These sudden events have handicapped millions of people largely because of their unpredictable occurance. In addition, myths and superstitions have inaccurately associated epilepsy with the devil and the supernatural for hundreds of years. Epilepsy is not cured, but is controlled in the majority of cases through the use of medications. (See Chapter 9.)

Epilepsy, like the other developmental disabilities, may result from brain defects during development which are caused by diseases, brain injury, and toxic substances passed to the child during pregnancy. It is equally important to note that unless controlled, seizures can cause further brain damage.

A significant difference with epilepsy as a handicapping condition is the overall effect on the life of the individual. Except in rather rare instances, the majority of a person's activities are quite typical and the presence of epilepsy is not apparent. It only becomes readily noticable during the seizure. Seizures may range from a slight jerk or momentary

loss of purposeful behavior to a complete loss of balance and consciousness accompanied by large muscle activity, i.e., arms, legs, body set in motion. Three main types of seizure are Petit Mal, Psychomotor, and Gran Mal.

A Petit Mal seizure is a very brief discharge of energy from the brain. It may appear as a quick nod of the head, a sudden lapse of activity, or an object dropped from a grasp. These seizures may occur at a very high rate during periodic intervals, and may be the only type of seizure exhibited by some individuals.

Psychomotor seizures are characterized by stereotypic behaviors such as rocking on the balls of the feet, tapping or pounding a hand on a table or wall, or some other repeated motor activity.

One of the least common types of seizure is a Gran Mal; yet this is the seizure which most people think of when they hear the word epilepsy. While Petit Mal and Psychomotor seizures are often not recognized as seizures, it is impossible to ignore a Gran Mal seizure. The large amount of electrical impulses in the brain which are released during a Gran Mal seizure affect the total bodily system. One feature of a Gran Mal that does not appear with other seizures is an "aura." The aura often serves as an internal warning that a seizure is imminent. Individuals report that they experience a particular taste, sound, feeling, or vision prior to the convulsion. This aura can serve to prepare the individual for what is to follow. Learning to recognize the onset of a seizure can minimize the chance of possible injury.

During a Gran Mal seizure, the person loses consciousness and convulsions usually occur for one to three minutes. The person may lose control of bowels and bladder during the seizure. After the seizure has ended, the person may be confused and disoriented. Within a short time, the person is able to resume usual activities.

As mentioned earlier, epilepsy can be controlled through the use of medications, but once a seizure has started, it cannot be stopped. In the event that you are around someone having a Gran Mal seizure, there are two things you can and should do to assist the person. First, protect the person from injury. Remove any objects which the person might hit during the convulsion. Second, protect the person from embarrassment. Explain to any observers that the person is having a seizure and not to be alarmed. If the person has lost control of bowels or bladder, cover with a blanket or similar material. (See Chapter 9 for a complete discussion of seizure management.)

Individuals who have epilepsy are found in all age groups and all areas of social activity.

AUTISM

Autism is a handicapping condition which is marked by controversy among the experts as to its definition, associated causes and treatment or intervention programs. Autism is generally characterized by severe communication disorders, repititious and peculiar body movements, and a lack of social interaction with other persons.

Many ideas have been advanced to explain autistic behavior, but no single theory has received consistent support through research. One early view held that infants who were unable to develop a close, satisfying relationship with their mothers retreated into inactive or bazaar behavior, autism. Another, more recent, view places greater importance on the existance of defective sensory perception in the child. It is thought that because of the defective perception, the child sees, hears, smells, tastes, and touches an environment which is not the same as others perceive it. Thus, the child experiences a personal world which is unable to be entered by others.

Family counseling, specialized educational programs, and some medications have been combined to bring about significant improvement in the behavior of some autistic children.

In summary, the availability of trained persons working in a variety of programs can greatly reduce the effects of handicapping conditions associated with developmental disabilities. Each person who has the opportunity to develop new skills and behaviors, alongside other community members, contributes to his or her own development, as well as to the fuller development of society.

LANGUAGE AND COMMUNICATION

5

Communication is the process whereby one person is able to exchange feelings, thoughts, or needs with another.

Language is the set of sounds or symbols used in communicating. The language system may be verbal, vocal, or gestural.

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Communication is an act which involves the transmission and exchange of one's needs, desires, thoughts and feelings to another. It serves as a major means of integrating and orienting new members to a family, a community, or any larger group. It is essential to daily life that members be able to communicate with each other.

A language system serves as the tool by which information is expressed or received. The system can be vocal, gestural, or verbal. A cry or a shout, which are examples of vocal communication, are limited but effective tools for communicating with others. The cry may have more than one meaning, but if it brings another person into the immediate environment, the correct meaning is more likely to be understood.

Gestures may range from a simple wave of the hand as a form of greeting to the complex arrangements of finger and hand shapes which constitute finger spelling and sign language. Individual signs can be developed to support an increased growth in vocabulary which make communication more meaningful.

A very complex language system, but one which is not necessary to carry out communication, is the verbal system. Speech is a very complex behavior which represents one of man's highest achievements. A disfunctional language system, and especially delays or disorders in speech, serve to isolate and draw attention to persons with developmental disabilities.

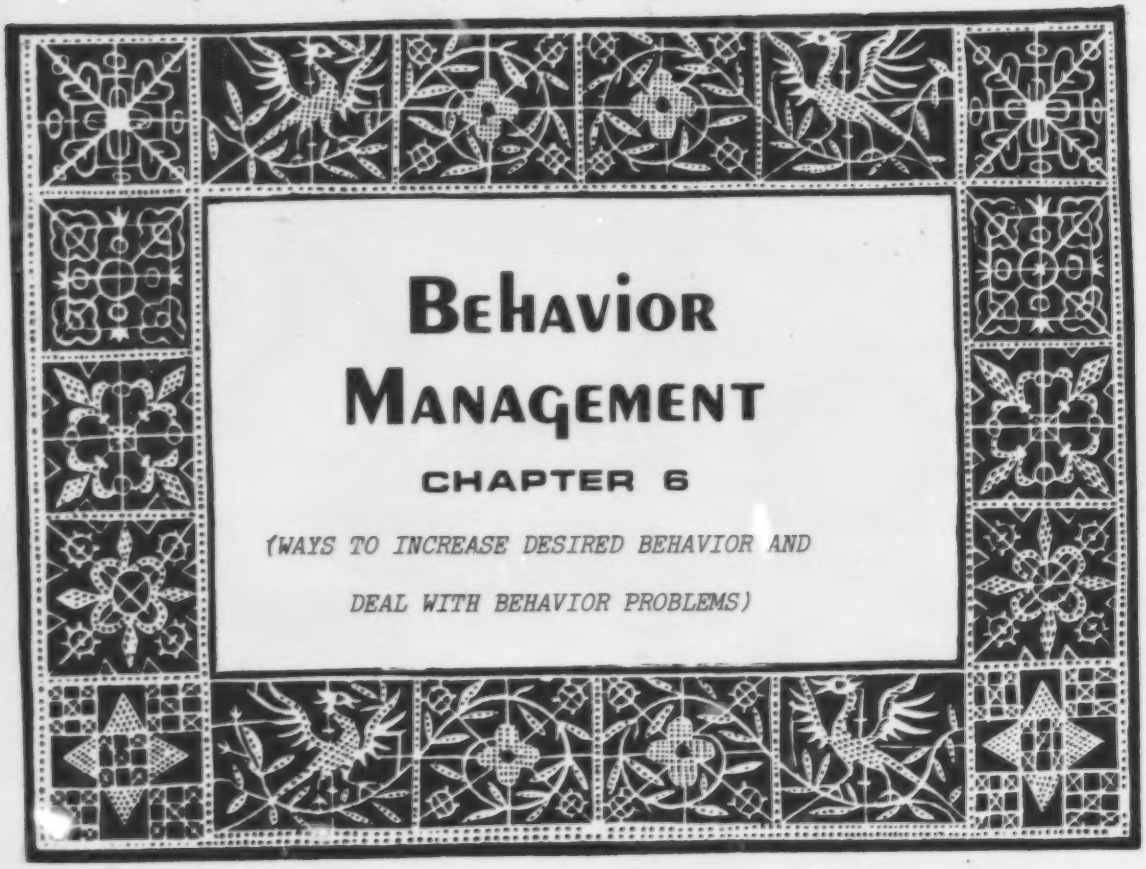
Your attempts to understand and communicate with the person you are providing respite care for should be carried out in the same manner as you would use in communicating with another friend. If you do not understand a sound, a gesture, or a verbal phrase, ask the person to repeat it. Do not pretend to understand if you are unsure of the meaning. You may spend a lot of time guessing and the person may spend a lot of time being silent.

In communicating with someone who does not have a highly developed language (you can not tell just by looking), you should provide as many cues as possible. Point as you say the name or ask for the name of an object. Look directly at the person and make sure that the person is aware that you are trying to communicate. Total communication, the use of multiple language systems, is very useful when communicating with young children and adults who are severely delayed in communication skills.

Two things to remember while you are communicating with someone: In normal language development, all children receive massive verbal and other sensory stimulation before generating or expressing any verbal behavior of their own. It is very important that you provide many opportunities for speaking and listening during your respite experience. Your interest and encouragement of communication efforts will contribute a great deal to the effective use of both receptive and expressive language.

The second thing to remember is directly related to the first. While you are providing experiences in the use of language, make sure that you encourage the person to initiate and express his or her needs, thoughts, and desires. Ask questions and provide ample opportunities for the person to reply. A major problem which individuals with delayed language encounter in communicating with others is that they often do not get to finish what they are saying. Many people try to anticipate what the other individual is saying. Many people attempt to supply the end of the thought or initiate a response before all the information has been expressed.

Your ability as a respite care provider will increase dramatically as you become comfortable and confident in communicating with individuals who have a developmental disability. Be yourself and take additional cues from the individual and his or her family. You will find that your interests, desires and feelings will be increased during a respite care experience, in addition to those of the person you are working with.



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As a respite care provider one of your responsibilities will be to maintain structured learning programs which parents have initiated with their children. It is extremely important, therefore, that you are familiar with some of the basic principles of behavior which will assist you. This training is not meant to equip you with all of the skills necessary to structure and facilitate new teaching programs with your client, but rather to allow you to support the efforts of the parents in their training activities.

Behavior is defined as any observable action. The basis for the teaching strategies in working with all people is that behavior is a direct result of its consequences. If a pleasurable event follows a particular behavior, then that behavior is more likely to be repeated. The reverse of that statement is also true; if a behavior is followed by an unpleasant event, then that behavior is less likely to be repeated.

The first major principle for increasing and maintaining behavior is the principle of positive reinforcement. Postive reinforcement is a method of increasing behavior by following the behavior with a pleasant event. Make sure that the reinforcement which you use is pleasurable to the client. You, as a respite care provider, will rely on the client and parents for the identification of those things which the client finds reinforcing. You should note that items or actions which one individual finds pleasurable may not be so for other individuals. Practically anything can be used to strengthen a behavior, from a smile, a pat on the back, going for a ride in the car, being left alone, to an edible snack. The important thing to keep in mind is that a reinforcer is only a reinforcer if it actually increases a behavior.

The second factor which impacts the effectiveness of the reinforcement principle is the need for immediate delivery. If someone has made their bed it is much more effective to tell them that you are pleased immediately upon completion rather than several hours later. Another important facet in improving the effectiveness of the reinforcement principle is that the delivery of the reinforcement should be behavior specific. For instance, if you're pleased that someone is sitting still, they should be told during the delivery of the reinforcement what it is that you are happy about.

Remember that positive reinforcement helps increase the likelihood that a behavior will be repeated. People often ask, "Isn't giving people reinforcers just bribery?" The answer is no. The very definitions of the words point out the distinct difference. A bribe is a gift or favor bestowed upon someone to corrupt a view, judgement or action; in short, a bribe is a reward for illicit or illegal purposes. Reinforcement means simply to strengthen, as in the reinforcement of a battle position, etc. What we are attempting to strengthen when working with people is new, desirable, acceptable behaviors and skills. Your paycheck is a reinforcement, it isn't a bribe.

Another technique of teaching new skills to an individual is to demonstrate the skill which you would like them to learn. This is called modeling. Modeling can be an effective method for teaching new behaviors. It is necessary for you to demonstrate the task clearly and precisely. It may be necessary for you to talk through the steps as you are doing the task. Also you may have to demonstrate the skill in small sequenced steps to effectively communicate the task. Many individuals may be able to learn rather complex skills by this simple method; for others, however, it may be less useful. The correct imitation of a behavior you have just modeled should always be reinforced.

Shaping is a method of increasing a behavior by rewarding closer and closer approximations to the desired task. For example, some parents may be working on an eating program in which their child is learning to eat with a fork. First you may reinforce reaching for the fork, then you would not reinforce unless the person picked up the fork and so on. When shaping a new skill, you should reinforce often to keep the client successful.

Another factor to keep in mind as you are doing programs that the parents wish to have continued is that for many individuals with learning difficulties a new behavior has to be broken down into very small component parts for the individual to learn. It is extremly important that you find out from the parent what step of the program the individual is on so that you will be able to deliver the reinforcement at the correct time. It may also be helpful to remember that when teaching a new task through a series of steps, you can approach this either backward or forward. Let's look at putting a sock on as an example of a new skill that one of your clients is learning. In the forward chaining procedure, the first step of the chain is taught first. So the person would be taught first to pick up the sock. After he/she has mastered that step, the other steps would be taught in order of their natural sequence. So the second step would be preparing the sock for the foot. In the backward chaining procedure, the last step in the chain would be taught first. In the example of putting on a sock, all the steps leading up to the last step would be done by the trainer and the last step of pulling the sock up to the final position would be done by the client. One of the good points of backward chaining is that the client is always reinforced for doing the last step.

Just as parents may wish for you to continue programs that are strengthening new behaviors, they may wish for you to be extremely consistent with their programs for decreasing behaviors. There are essentially two major categories of techniques for reducing behavior.

The first of the two is called extinction. Extinction is a method of reducing the likelihood that a behavior will be repeated by following that behavior with a neutral response. Simply put, it means that behaviors which are ignored tend not to be repeated. This is an important concept to keep in mind for not only does it work effectively in reducing many undesired behaviors, it also can work to weaken desired performances. None of us would, of course, purposefully ignore the completion of a desired behavior, skill or performance, but frequently we do it inadvertantly.

Sometimes those accidental incidents of extinction can significantly reduce the chances that a desired behavior will be repeated, another good reason to always be alert for opportunities to reinforce desired behavior. So the first and simplest method of decreasing the likelihood that a behavior will be repeated is to simply ignore it.

The second major category for reducing behaviors is much more inclusive and is called punishment. Punishment is defined as a method of reducing the likelihood that a behavior will be repeated by following that behavior with an unpleasant event. Many of the same principles which can increase the success of reinforcement also can increase the effectiveness of punishment. The punishment should follow the event immediately and should once again be behavior specific. There are some general pitfalls in using punishment as a method of changing behavior. The results are not as predictable as with other methods and frequently the results are not long-lasting.

Punishment techniques which may be used by a parent may include everything from time out, overcorrection, loss of treat, to a spanking. In all cases, make sure that you know what the parents do for what behaviors and what they expect you to do. If you are not comfortable carrying-out the programs they have set up, tell them so. The honesty will be appreciated, and this should be worked-out between you and the family. Be consistent with parental expectations. In many instances, if there are indications that the behavior is forthcoming, a change of environment can be enough to avert the situation. Always remember that the positive approach of reinforcing desired behavior is the best and that punishment is the least predictable method of behavior change.

One last technique which sometimes helps you to maintain control of the situation and allows you to reinforce appropriate behavior is contingency contracting. That is a phrase for something that has been around for ages, sometimes called Grandma's rule. Contingency contracting is the pairing of events so that the person will do a task he/she considers not very desirable so that he/she can have the opportunity to participate in a task that he/she considers highly desirable sometime later. For instance, father to teenage son, "If you mow the lawn this afternoon, you can have the car tonight." Mother to teenage daughter, "If you weed the garden this afternoon, you can have the car tonight." At any rate, contingency contracting allows you to reinforce a task that the person is not likely to do on his/her own. It also lets the person know exactly what he/she must do. Remember once again that immediate reinforcement strengthens the likelihood that the behavior will reoccur. Therefore, if the person completes their part of the contingency contract, make sure that you follow through as soon as possible with your part. Frequently the individual will give you clues as to what the reinforcing event might be; for instance, "I want to watch T.V." A perfect time to interject, "First let's work on your shoe tieing for five minutes and then we will watch T.V." If you are positive and expect good behavior, most often you will get it.

Techniques should be a little more subtle than this...

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GENERAL PRINCIPLES OF LIFTING, CARRYING, AND LOWERING

TO LIFT:

1. First plan the job.
2. Make sure there is ample room for good footing and the path is cleared for the carry.
3. Stand so you will not have to twist as you lift.
4. If the weight of the load is more than one fourth of your body weight, or if it is awkward, you should get someone to help you.
5. The back should be as straight as possible.
6. Lift by straightening the legs in a steady upward thrust and, at the same time, move the back to a vertical position.
7. The weight of the load should be kept close to your body and over your feet.

TO CARRY:

1. Carry the load as close to you as possible.
2. Keep your back straight, not arched.
3. Do not twist. Change direction by stepping around and turning the whole body.

TO LOWER:

1. Spread your legs to hip width and lower the load between your feet.
2. Hold your back straight and steady, even when you lean forward.
3. Lower in a slow and even manner by bending your legs.
4. Do not twist your body. To turn, move your feet.

Specifics for lifting and carrying the cerebral palsied person:

FROM: Handling the Young Cerebral Palsied Child at Home, p. 82-89, Nancie R. Finnie, Western C.P. Centre, London.

LIFTING:

1. Sit the child symmetrically before lifting him/her, bending forward at the hips. If resistance is felt, bring head and shoulders forward at the same time as you bend the hips placing your forearm just above the base of the skull.
   NOTE: With a heavier and older person, roll him/her onto his/her side before bending head and shoulders forward. By doing this, you facilitate bending of the hips.

2. When putting him/her down, use a sitting position, also.

3. After lifting the child from the seated position; keep his/her arms over your shoulders, hold his/her legs high up on the thighs, keeping them apart and turning them out.

RIGHT

WRONG

4. When carrying the athetoid or floppy child, lift and carry him/her by bringing his/her arms forward with your forearms in front of his/her arms and holding his/her hands over the lower part of his/her knees. The legs should be bent and pulled toward you, his/her back forward and away from you.

CARRYING:

1. After lifting the child from the sitting position, place his/her arms over your shoulders, (A), then part his/her legs and put them around your waist, (B). As the child learns to balance, gradually reduce your support, (C).

2. After getting the child in a seated position, lift him/her from behind and carry him/her by placing your forearms under his/her arms and your hands on the inside of his/her thighs, keeping his/her hips bent and pulled toward you and his/her back forward and away from you.

WHEELCHAIRS:

1. Make sure the chair is locked when removing the person or putting him/her in the chair.
2. Pull the wheelchair backwards up steps, curbs, etc.
3. Adjust the height of the foot pedals so the person is sitting at a 90 degree angle at the hip and knee unless he/she is in a posture 90 chair.
4. When removing a person from his/her wheelchair or putting him/her in it, the following procedure is suggested as easy for you and most comfortable for the person:

   Place one arm around the person and under his/her arm at the armpit. Place your other arm under the person's knees.

OR:

   Face the person in the chair, secure a hold under each arm, and lift out of the chair making sure you have put up the foot pedals or swung them out of the way.

LIFTING AND MOVING - From bed to wheelchair

Always begin lifting procedure by moving person to edge of bed, moving first the upper trunk, then the legs, one at a time. Repeat this until the person is near the edge of the bed. It is easier to repeat moving the trunk and then the legs instead of lifting patient as a whole all at once.

Remember, bend from your knees, not from your waist. If you must bend from waist, tighten stomach muscles while bending and lifting. This reduces pull on back muscles. Keep your back straight or vertical at all times.

One person lift:

1. Wheelchair, etc., should be close to bed but angled so it is not in your way.
2. The wheels must be locked and footrests swung back or removed.
3. Slide person to the edge of the bed (see above).
4. Position yourself near person's head and trunk.

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5. Slide one arm under person's upper trunk (under arms) and raise to sitting - make sure your knees are bent and one foot is positioned in front of the other.

6. Place your other arm in a cradle position under person's hips - straighten your knees, lift remembering to hold person close to you.

7. Turn a one-half (½) circle to face chair, lower person in it while bending your knees.

8. Fasten seatbelt and reposition feet on footrests.

From wheelchair to bed

1. Place chair at angle close to the bed.

2. Brakes of wheelchair must be locked and footrests swung back or removed.

3. Face the person, assume slight squat position (knees bent), place one foot in front of the other and encircle person at waist or upper chest.

4. Shift weight onto back foot, straighten knees, and you will lift person out of the chair.

5. Swing in a one-half (½) circle, put person's buttocks on bed.

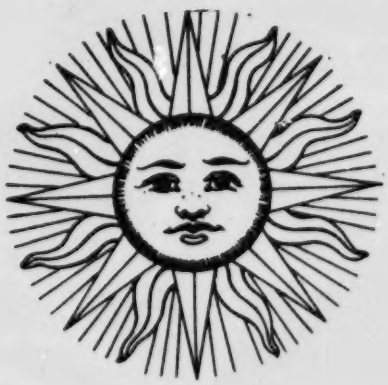
6. Next, place person's legs on the bed and move him/her to the center of the bed.

   If the person is too heavy, ask for help.

Two person lift:

1. Support upper trunk folding person's arms around his/her chest while second person supports person's hips and knees.

   Person should be requested to help you as much as possible.



UNDRESSING

Undershirt, Slip-on Sweater, Polo Shirt, and Dress

1. Duck-the-Head Method:

The person reaches to the back of the neck opening with one or both hands, ducks his/her head and pulls the neck opening forward over his/her head. His/her lead hand then grasps the edge of the opposite sleeve and pulls the sleeve off his/her arm. The involved hand then pulls the sleeve off the lead arm or the person shakes the sleeve off.

2. Arms-out-First Method:

For short sleeves, the lead hand grasps the edge of the opposite sleeve and pulls it forward over his/her elbow as the involved arms pulls back through the armhole. For long sleeves, the person raises his/her involved arm to shoulder level, flexes his/her elbow, then the lead hand grasps the underarm of the sleeve and pulls it down and forward while the involved arm pulls back and out. Follow the same procedure for the other side, with the involved hand now pulling down. The person now takes his/her head out as in the duck-the-head method.

Cardigan, Coat, Jacket and Open Shirt

1. Flip-over Method:

This method is particularly good for those unable to place arms behind their backs and also for individuals who are retarded. The person leans forward, ducks his/her head, grasps his/her garment at the back of the neck with both hands and pulls it forward over his/her head. The person then pulls the garment, which is now in front of him/her, off both arms.

2. Arms-in-Front Method:

The person puts both hands behind his/her back, pulls the sleeves off the involved arms with the lead hand, then brings arms forward and removes the sleeve from the lead arm.

Trousers, Skirt, and Underpants

1. Lying-down Method:

The person pulls his/her garment down over buttocks while he/she rolls from side to side or he/she may arch his/her back and then push garment down. He/She then wiggles his/her body back and out. He/She usually kicks the garment off the feet.

2. Sitting-up Method:

a. Chair: The person braces his/her feet and hoists his/her body, using both hands to push his/her garment down over his/her buttocks; or he/she may hoist his/her body with one arm and use the other to push garment down. He/She finishes by leaning forward and pulling the garment up by the cuffs or hem or simply kick it off.

b. Mat: The person starts by pushing his/her garment forward while wiggling his/her body back and out or he/she rolls from side to side while pushing his/her garment forward. He/She finishes by either bending his/her knees close to his/her body and pulling garment off by the cuffs or hems or, for trousers, by crossing legs and pulling one cuff off at a time.

3. Kneeling Method:

The person pulls his/her garment down over his/her hips and buttocks, then he/she sits and finishes as in the sitting method.

4. Fair Standing Method:

The person holds onto a piece of stable furniture with one arm or he/she leans against it. He/She starts by pushing his/her garment down past his/her knees with one or both hands and finishes by sitting and pulling off as in other sitting methods or simply steps free of it.

Shoes

Shoelaces may be loosened or unlaced if the person is unable to do this for himself/herself.

1. Boot-Jack Method:

With his/her shoe wedged in a boot-jack, the person pulls foot out while shoe remains in the boot-jack. Boot-jacks may be purchased in stores dealing in riding equipment or made from wood.

2. Rub Method:

The person dorsiflexes the ankle and rubs the back of his/her shoe off against the mat or footstool or the toe of his other shoe.

3. Push-Pull Method:

With one foot resting on his/her opposite knee, the person pulls the toe of his/her shoe up with one hand while he/she pulls the heel down with the other hand. This may also be done with the legs uncrossed.

Socks

1. Rub Method:

The person pushes and rolls the sock down as far as possible, using either one or two hands or by rubbing against a mat. He/She then finishes by grasping the toe of the sock and pulling it off.

2. Hook-and-Pull Method:

The person hooks his/her thumb or fingers at the back of the sock directly above the heel and pulls straight down over his/her heel. He/She then grasps the toe of his/her sock and pulls it off.

DRESSING

Undershirt, Slip-on-Sweater, Polo Shirt and Dress

1. Duck-the-Head Method:

The person grasps the back bottom of the garment, ducks his/her head forward and pulls the garment over his/her head. Lead hand then holds the bottom open wide while the involved hand pushes through the armhole. Repeat for the lead arm.

2. Arms-in-First Method:

The person lays the garment flat on his/her lap or on a table, with the front side down. He/She then opens the back bottom of the garment with his/her lead hand and pushes his/her involved arm into the sleeve. The lead hand then pushes the sleeve up past the elbow of the involved arm. Repeat for the lead arm. Lead hand now firmly grasps the back of the garment and pulls it over his/her head. Finish by pulling down all around.

Cardigan, Coat, Jacket, and Open Shirt

1. Flip-over Method:

The person lays the garment flat on his/her lap or on a table with the collar near his/her body and the lining showing. He/She then pushes both arms into the sleeves, or the involved arm first, lead arm second. He/She then ducks his/her head forward while raising extended arms over his/her head. Finish by shrugging shoulders and pulling down.

2. Pull-from-Front Method:

The person pulls the sleeve over his/her involved arm, lead hand grasps the opposite shoulder and pulls it over his/her head to the other shoulder and grasps it with the involved hand, holding it. He/She then finds the armhole with his/her lead hand and pushes arm into sleeve.

Trousers, Skirt, Underpants

1. Lying-Down Method:

The person puts both feet, or one foot at a time, into garment and while he/she rolls from side to side, he/she pulls the garment up. Or he/she wiggles forward into the garment by a series of arching movements while pulling up with both hands.

2. Sitting Method:

(a) Chair: The person holds the garment open and puts both feet in or, with trousers, he/she rests his/her ankle on the opposite knee and puts one pants leg on, then repeats for the other leg. He/She then pulls garment up past his/her knees, hoists his/her body with one arm or by bracing his/her feet and finishes by pulling up past buttocks with one or both hands.

(b) Mat: The person holds garment open and puts both feet in. For trousers, he/she crosses involved leg over opposite knee and puts pants leg on; or he/she picks up one leg at a time and, with knee bent close to the body, puts foot into pants leg. Using either method, he/she repeats for the other leg. He/She then pulls garment up past his/her knees and pulls on the rest of the way by wiggling his/her body forward into it, or by rolling from side to side.

3. Kneeling Method:

Start as in sitting method, on a mat, to get feet into garment. After the garment is pulled up past his/her knees, the person then kneels and pulls it up past buttocks with one or both hands.

4. Fair Standing Method:

Start as in sitting method, on chair. The person then holds onto furniture with one hand and pulls garment up with other, or leans against the wall and uses both hands to pull up.

Socks

1. Scuff or Fold-in-Half Method:

The upper part of the sock is folded back at the heel so that the sock looks like a scuff slipper. The person grasps both sides of the folded sock, puts his/her toes in, and pulls the sock over his/her foot. He/She then grasps the cuff of the sock and pulls it up over heel and up leg.

Shoes

1. Box Method:

The shoe is placed in a box in front of the person, or against furniture or wall. The person plantar flexes his/her foot, points toes into the shoe and then pushes foot forward and down.

2. Shoe-Horn Method:

The person inserts a shoe-horn in the back of his/her shoe, puts his/her toes in and pushes down and forward with his/her foot as he/she removes the shoe-horn. This is especially useful with high-top shoes.

3. Pull Method:

The person rests one foot on the opposite knee or simply lifts his/her foot up. He/She then holds the shoe open in front, including the tongue, plantar flexes his/her foot and pushes toes in while the other hand pushes up on the bottom of the shoe.

Dressing - Cerebral Palsy

Dependent:

When you must dress or partially dress a person who is spastic, these two positions are recommended:

1. Put the person in a sitting position with his/her back to you either on your lap or on a stool between your legs. Feet should not dangle but be placed on a firm surface.
2. Put the person in a side lying position on the bed and roll him/her from side to side as is necessary to get the clothes on. This is the best position if the person is too heavy to hold or control on a stool.

NOTE: A supine (on the back) position, the one often used, causes the person to react by flinging his/her head back, arching his/her back, and extending (stretching out) at the hips and legs.

When dressing a person who has one side more involved (hemiplegic) than the other, put the sleeve of the dress, shirt, coat, etc. on the more involved arm first. When undressing the person, take the sleeve off the least involved arm first. This is also important for independent dressing.

Independent

In order for the person to dress himself/herself independently, he/she needs to be able to:

1. Maintain a sitting balance and have adequate trunk control so that arm motions will not throw him/her off balance. This is necessary for undressing as well as dressing. If he/she needs support of one arm to maintain balance, leaning against the back of the bed or wall may provide needed support.
2. Move his/her arm purposefully in a desired direction to reach the necessary garment and to lift himself/herself up in order to remove slacks, pants, etc.
3. Grasp and then release an article of clothing in order to take clothes off and put them on. Fine finger dexterity is not necessary unless the person is doing shoe lacing and tying, buttoning, etc. Some hemiplegic persons are able to do very well with one hand.

The athetoid person often finds it easier to dress himself/herself while he is sitting on the floor as it is a more secure position for him.

The spastic person often finds it more comfortable to dress himself/herself while sitting on a chair, on the bed, or in a kneeling position on the floor.

A person with poor trunk control and balance may be able to put his/her pants on in a lying position; transfer to his wheelchair and then put on his shirt, socks, and shoes.

It should be remembered that for most persons undressing is easier than dressing.

BRACES:

When putting braces on, here are a few points to remember:

1. Have the person lie on a firm surface.

2. Put the shoes on first. They may either be attached to the shoes permanently with stirrups or be removable.

3. Unlace the shoe completely. Position the leg with the knee bent and the hip rotated inward or outward. Be sure the toes are up, (not curled) and the heel is down in the shoe. Tell the person what you are doing so he/she will be relaxed.

4. After shoe is on, extend the leg, lock the knee, fasten the knee pad (if he has one), fasten the calf and thigh cuffs, and the pelvic band (if he has one).

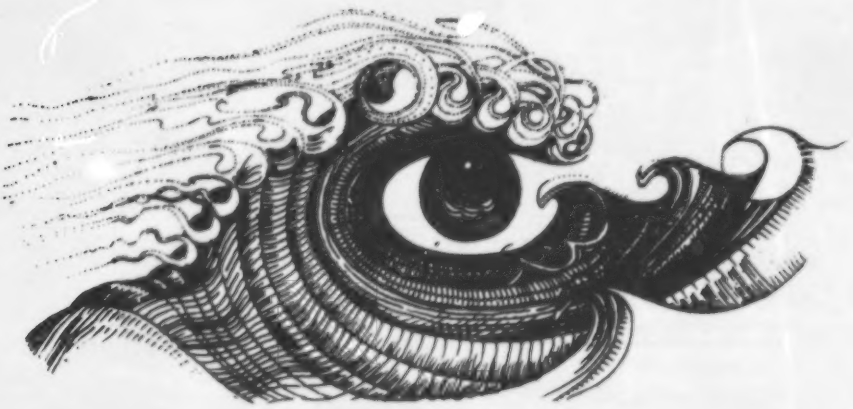
5. AK braces can be worn over or under clothing. BK braces are usually worn under pants, but over socks or tights.

Remember:

1. Check the person's skin for any localized redness. blisters, or pressure sores, which may develop from braces and shoes which are tied too tight, do not fit well, have not been on properly, etc.

2. Make sure all screws and bolts are tight.

3. Clean leather with saddle soap or other commercial cleaner.



SPECIAL ADAPTATIONS FOR THE BLIND

Orientation and mobility are skills which allow blind persons to move around easily and safely.

Orientation: learning about objects around oneself (using environmental clues)

Mobility: learning how to move about in one's environment

Coordination, body image, balance, position in space, etc. are also important in the physical and motor development of the blind individual.

SIGHTED GUIDE: a person with vision acting as a guide for a blind individual

HOW TO be a sighted guide:

- give verbal descriptions of the objects you come in contact with
- give person chance to explore them tactually
- stand beside person and face the same direction
- the person should grasp your arm with his thumb on the outside of your arm, firmly but not so it is uncomfortable to you. If he/she is too short to reach your elbow, he/she can hold your waist.
- the person stands while you step one-half space forward and then maintain this position as you walk. It is important as it lets the blind person know what kind of movements you are making.
- practice turning corners, stopping, starting, etc.
- when going through a door, the blind person should move behind the sighted person so he does not bump into objects.
- never leave the blind person in an open space. Place him in contact with the wall, counter, chair, etc.
- the person should know the location of rooms, furniture, and other objects he/she will need to use. REMEMBER: Inform the person if something has been moved.

DROPPED OBJECTS:

-teach the blind person to listen for the general direction of the sound made by the falling object.

-have him/her face that direction, with hand before face, palm facing out, and move one-half step backwards.

-teach him/her to bend at the knees and squat down. NEVER direct the blind person to bend from the waist as he/she may bump his/her head on some object he/she does not realize is there.

-while in the squat position, he/she should place his/her other hand where he/she thinks the object fell. Then he/she should make a small circle movement on the floor with one hand, getting bigger until the circles are as big as he/she can reach or until the object is located. If he/she does not find it, he/she should be directed to move a little and begin searching again.

LOCATING A CHAIR:

-the sighted person should help the blind person to place his/her hand on the back of the chair so he/she knows the direction the chair is facing.

-the blind person can move to one side to get around the chair with one hand remaining on the back and the other hand locating the chair seat.

-the blind person keeps moving until he/she is directly in front of the chair, turns so his/her back is to the chair, feels the edge of the seat with the back of his/her legs, and sits down.

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BRACES

Cuff - band of leather located at the thigh and/or calf; may be secured by velcro or leather straps with buckles.

Joint - found at the ankle, knee, and hip -- permits movement at these areas when brace is unlocked.

Knee Pads - portion of leather (padded) which is strapped over the knee to keep it in better position when weight bearing and when braces are locked.

Stirrup - metal part at the bottom of the brace. It fits into the shoe at the heel.

Surgical Shoes - shoes that unlace to the toe.

T-strap - worn around the ankle and may tie on either the medial or lateral side of the ankle - necessary to maintain foot in as normal a position as possible when weight bearing.

Twisters - cables attached to shoes and pelvic band and worn on lateral side of leg -- to control internal rotation from the hip.

FEEDING

Finger Feed - uses fingers rather than utensils when eating.

Palmar grasp - using all fingers to grasp objects while holding it in the palm of the hand.

MOVEMENT AND MOTOR DEVELOPMENT

Ambulatory - walking; able to walk.

Body image - individual subjective opinion about his identity; his emotional perceptions about the worth of his body and its functions.

Coordination - to act together in a smooth way; several muscle groups working together in harmony.

Fine motor - small muscle movements.

Gross motor - large muscle movements.

Mobility - learning to move about in ones environment using transportation, one's own abilities.

Orientation - learning to use environmental cues (objects, etc.).

PHYSICALLY HANDICAPPED

Ataxic - primary incoordination due to disturbance of balance or kinesthetic sense or both -- characterized by inability or awkwardness in maintaining balance or coordination -- awkward when sitting down.

Athetoid - uncontrollable, jerky, irregular twisting movements of extremities -- especially noticeable in wrists and fingers, postures are constantly changing.

Cerebral Palsy (C.P.) - A condition which is non progressive; non curable but is amenable to training and therapy.
Cerebral Palsy is characterized by paralysis, weakness, incoordination, or other abberation of motor function due to dysfunction of the motor centers of the brain.

External rotation - rotating outward at the hip joint or shoulder joint.

Extend (extensor, extension) - to straighten at a joint.

Hemiplegia - one half of body - arm usually most involved and spastic - use involved arm as a helper, to hold object.

Hypertonic - increased muscle tone.

Hypotonic - decreased muscle tone, floppy child.

Internal rotation - rotating inward at the hip joint or shoulder joint.

Mixed - combination of one or more -- this is the most frequently encountered type according to several experts. Hypertonicity and hypotonicity.

Paraplegia - legs only involved.

Prone - the individual lays on his stomach.

Quadriplegia - all four extremities -- greatest involvement in legs, usually spastic -- greatest involvement in arms, usually athetoid.

Scoliosis - spinal deformity noted by an S curve of the spinal column -- can vary in degree of severity.

Spastic - hypertonicity, exaggerated stretch reflex, movements are small and labored. Tendency toward contractures due to a maintenance of a few abnormal postures.

Supine - the individual lays on his back.

Weight bear - to accept and support one's own weight while on extended arms; in a 4-point position; on knees; standing, etc.

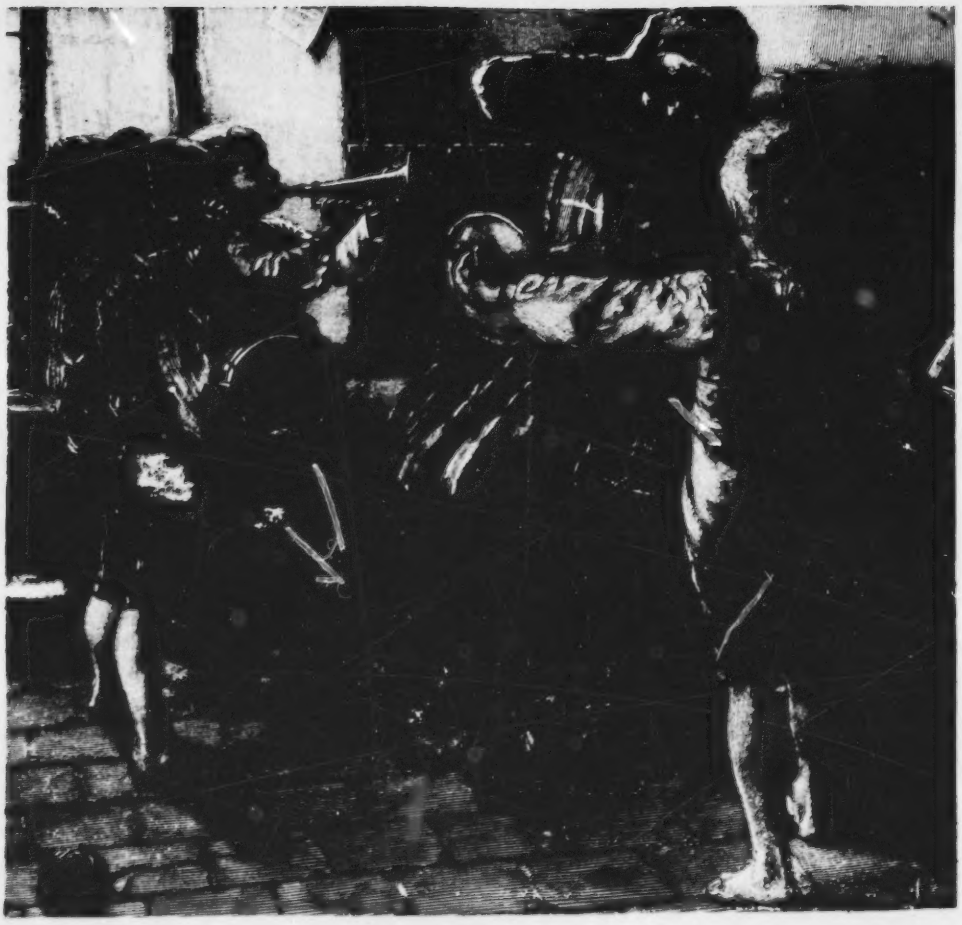
Glossary cont'd

TOILETING

Creeding - manual push on bladder to facilitate its complete emptying.

Toilet Scheduled - certain times at which you must send or take person to bathroom -- may be charted.

Toilet Trained - person knows when he needs to use toilet and goes independently or asks for help.



Programming Activities

chapter 8

(Activities that assist in the development of specific skills or behaviors and allow you to be consistent with parental desires)

Selected Bibliography

Anderson, F.B. Fay's First Fifty: Activities for the Young and Severely Handicapped. FACT, Augusta, Georgia, 1974.

Baldwin, Fredericks, Brodsky. Isn't it Time He Outgrew This? Or A Training Program for Parents of Retarded Children. Charles C. Thomas, Publisher, Springfield, Illinois, 1976.

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Cole, Haas, Heller, and Weinberger. Recipes for Fun. 464 Central Avenue, Northfield, Illinois, 1970.

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In order for you to provide an enjoyable respite experience for the client with whom you are working, it is necessary for you to become familiar with the routine of that family and client. Every family unit has a little different pattern of daily living. By understanding that pattern you will be able to give the client a new set of experiences which will be consistent with parental guidelines. A list of likes, dislikes, interests and reinforcers gathered prior to the respite outing will prove useful. A sample client information form which is useful for gathering this information, as well as medical needs, is provided on pages 46 and 47.

There are many structured programs that parents may expect you to continue as respite care providers in their absence. The vast majority of interaction, however, will be on a much less formal basis. Much of this informal time together can be designed to support the desired growth and development of an individual. Although continuous structured programming would be exhausting to the client and you as the respite care provider, every opportunity to provide experiences which can serve as learning experiences for the client should be encouraged. A high rate of interaction should be maintained at all times, even with little or no response from the client. Once again, this contact serves as a basis for new experiences, upon which the development of new skills are based.

Although there are no hard and fast rules that can be applied to structure informal learning activities, the following guidelines are offered as suggestions to increase their effectiveness:

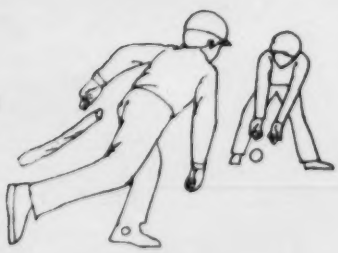
Involve the persons from the start. Attempt to do things the client wants to do. This will help to insure his/her enjoyment, longer involvement in the task, and consequently help to guarantee success. As was discussed in the behavior management chapter, one way of increasing desired behaviors is to identify events which the individual finds to be reinforcing. Since you are encouraging the client to help select the activity, you are more likely to be involved in activities which the client finds to be enjoyable. This will increase the chances of using this activity to enhance skill maintenance and acquisition.

The basic guidelines of normalization and the developmental approach should be considered when developing activities for developmentally disabled clients. For instance, if a 20 year old woman identified as one of her favorite activities coloring in a coloring book, there are ways of shaping on that activity to make it more age appropriate. Working on the paint-by-numbers set may provide much the same enjoyment, but will encourage the recognition of numbers as well as being a more appropriate artistic media. Of course, a primary consideration is providing safe and enjoyable experiences to the client which are consistent with the parental desires and expectations. You, as a respite care provider, may be able to suggest and encourage new activities which would not ordinarily be undertaken by the client, which are more normalizing and age appropriate.

In order to encourage success and enjoyment of the activity, goals of that activity should be attainable by the client. Time available and the client's

ability level are two factors to keep in mind when working on new activities. There may be great opportunity for the learning experience, as well as enjoyment, by encouraging the client to participate in making a batch of cookies. But this may be a futile and frustrating activity if it is started too late in the evening to be completed before the client's bedtime. Likewise, physical activities should be geared to the client's fitness, interests and ability to perform the task. Asking clients to engage in physical exercise which is beyond their current capabilities will not only be discouraging at that point, but may also discourage their participation or willingness to try that activity again.

Both structured and unstructured activities provide opportunities for the development of a wide range of skills including the refinement of appropriate social behaviors such as concentration and sharing. By interacting with the client you are, of course, increasing opportunities to demonstrate and learn new communication skills. Participation allows the person to become a doer and not merely a spectator, with the result being better fine and gross motor skills. Successful completion helps to build self-confidence and a positive self image. Activities help to establish a good working rapport between the client and the provider. Remember to consider your personal resources when providing new experiences for the client, as well as scouring the community for activities which will be enjoyable and enlightening to the client.



Parents Name_____ Social Security Number_____

Clients Name_____ Insurance Company_____ No._____

Nickname_____ Birthdate_____

PERSONAL SKILLS:

EATING:

Special diet_____ Type_____

If they refuse to eat_____

Feed themselves_____ Known allergies_____

Favorite foods_____ Dislikes_____

Other Instructions_____

_____

_____

DRESSING:

Do they dress themselves_____

Need help with_____

Other Instructions_____

_____

_____

SLEEP:

At night sleeps from _____ to _____ Average hours_____

Naps from _____ to _____ Average hours_____

General attitude_____

If refuses _____ Wets the bed_____

How handled_____

Other Instructions_____

_____

_____

TOILETING:

What times taken to the bathroom_____

Do they take themselves_____ Do they indicate need_____

Special devices_____

Other Instructions_____

_____

RECREATION:

Interests_____ Dislikes_____

Other Instructions_____

_____

Any special behavior problems_____

How they are handled_____

Other comments:_____

MEDICAL INFORMATION

Family doctor _____ Phone _____

Dentist _____ Phone _____

Other Specialists _____ Phone _____

_____ Phone _____

Medication or treatments:

Name	Dosage	Time

Seizures:

Type _____ Frequency _____

Blood Type _____

Known allergies:

Medications _____

Foods _____ Other _____

Treatments _____

Other specific medical problems _____

_____

_____

General physical condition _____

Can you be reached _____ Phone _____

_____

When will you return _____

Friend or relative to contact in event you cannot be reached _____

_____ Phone _____

Other instructions _____

_____

_____

_____

CHAPTER 9

General Medical Problems

(The proper immediate treatment of common household emergencies as well as the recognition of serious injuries which require medical attention)

Selected Bibliography

Advanced First Aid and Emergency Care. The American National Red Cross. Doubleday and Co., Inc., Garden City, New York, 1973.

Cardiopulmonary Resuscitation. The American National Red Cross, 1974.

Grant, H., and Murray, R. Emergency Care. Robert J. Brady Co., Bowie, Maryland, 1975.

Physician's Desk Reference. Medical Economics Co., Oradell, New Jersey, 1975.

Wright, George N., Ph.D., Eds. Epilepsy Rehabilitation. Little, Brown, and Company, Boston, 1975.

FIRST AID TRAINING

Because of the abbreviated length of this portion of your training it is impossible to give you a complete background in emergency care. This session should provide you with some very basic treatment procedures of the problems you are most likely to encounter as a residential provider. One of the most important aspects of this training session is to leave with you resources which will help you increase your overall skill levels. In the area of general first aid training your local chapter of the American Red Cross should be able to help you find and attend any of the following classes.

Standard First Aid, Multimedia System. This is a fast moving class which utilizes films, workbooks and practical sessions to cover the basic life threatening emergencies. This course is eight (8) hours in length and can be broken down into four 2 hour sessions. The only requirement for the registration in this class is to be 13 years old or to have completed the 7th grade. The major attractiveness of this class is the abbreviated length. Because of the programmed nature of this course, it can not deal with specific interests in a variety of topical areas.

Standard First Aid and Personal Safety. This class is similar in basic content to the above class but the method of instruction differs. It is primarily lecture by an instructor as well as practical work on splinting, bandaging, and other areas. This class is a minimum of 14 hours in length and basic requirements are the same as for the Multimedia course above. This class can take the time to address special areas of concern in more detail than the above class and provides useful information.

Advanced First Aid and Emergency Care. With the minimum of 52 hours of instruction this course is the most comprehensive first aid course offered by the American Red Cross. Because of its length it can go into much greater detail on all of the major topics covered in either of the two above mentioned courses. This course should prepare you for any situation you might encounter as a residential provider and would be recommended. Minimum entrance criteria is 15 years or 10th grade. Method of instruction utilizes lecture, practical sessions, and mediated support.

Cardiopulmonary Resuscitation (CPR). CPR concentrates on providing you with the skill required to keep someone alive if their breathing and heartbeat have stopped. The techniques of mouth to mouth respiration and external chest compression are explained and the opportunity is provided for you to perfect these skills. Both the American Red Cross and the American Heart Association offer this class, they are both of equal value and are presented in a very similar manner. The length of this class is about eight (8) hours and the minimum age for enrollment is 13 or completion of the 7th grade. This is a valuable class for you as a concerned citizen. If you have any questions about this or any other first aid classes, you should contact your local chapter of the American Red Cross.

Emergency Medical Technician (EMT). This class is 81 hours in length and is instructed primarily by physicians. The course includes hospital instruction and observation and is specifically designed for ambulance and other first response personnel. Since much time is spent practicing with specialized equipment which may not be readily available in general first aid situations some of the material is not applicable. Entrance criteria is recommendation by a course committee. Certification is by the State Board of Medical Examiners.

FIRST AID REVIEW

AIRWAY OBSTRUCTION AND LACK OF BREATHING should be your first concern in any unconscious or seriously injured person. Most airway obstruction is caused by the tongue falling back against the back of the throat; this can be corrected by tilting the head back to lift the tongue forward. If the person does not resume breathing by proper positioning, pinch the nostrils with the thumb and forefinger of one hand, open your mouth wide and seal it over the victim's mouth, and blow the air from your lungs into the victim's mouth. Continue this process at a rate of once every 5 seconds for an adult and once every 3 seconds for a child.

NOTES:

CONTROL OF BLEEDING can usually be accomplished by applying pressure directly to the wound with your bare hand or an absorbant pad. If this does not control the bleeding after 5-10 minutes, or if the wound is serious, then you should find the pressure point and depress it against the bone. The pressure point for the arm is located on the inside of the upper arm in the groove between the top and bottom of the arm. The pressure point for the leg is located halfway between the hip bone and the pubic bone.

NOTES:

POISONING: The first step in the treatment of poisoning by mouth is to dilute with one to two glasses of milk or water. Call for information as to specific procedure for that particular substance (ROCKY MOUNTAIN POISON CONTROL CENTER, DENVER COLORADO, 303-629-1123). If the substance is not an acid, alkalai or petroleum product, induce vomiting; Syrup of Ipecac is the most effective. Transport to a medical facility, save the container or a sample of the vomit.

NOTES:

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SHOCK is a collapse of the heart and blood vessel system. Shock can occur in any seriously injured person and should be treated for. Maintain body heat and elevate the feet if there are no major head injuries; stay calm and reassure the victim; control all bleeding and splint all fractures.

NOTES:

BURNS: First degree, the skin is reddened; second degree, blisters form; and third degree, the skin is destroyed and underlying tissues are damaged. For first and second degree burns, cool the area by immersion in water or application of cold compresses. When the area is cool to the touch, cover with a sterile dressing. For a third degree burn, cover with a loose sterile dressing and seek medical attention. Do not use butter or creams in the treatment of a burn and do not cover a burned face.

NOTES:

FRACTURES: Any fracture or suspected fracture should be immobilized before moving the victim. If possible, do not move the victim until trained personnel with proper equipment have stabilized the fracture. Pad the splint well and attempt to immobilize the joint above and below the fracture site. Elevate the limb after splinting.

NOTES:

DIABETES is a metabolic disorder in which the person is unable to use the carbohydrates in his/her diet. If a known diabetic is found unconscious for no apparent reason, place simple sugar under his/her tongue. Seek medical attention.

NOTES:

EPILEPSY is a neurological disorder manifested by seizures. There are several different types of seizure patterns.
Petit Mal is a momentary loss of awareness and generally does not require any special emergency care other than pausing momentarily to allow the individual to become reoriented.
Psychomotor seizures are characterized by repetitive motor movements; the person may lose consciousness.
Grand Mal seizures are characterized by a loss of consciousness and the individual falling to the ground. There may be jerking muscular movements or muscle rigidity.
Status Epilepticus occurs when the individual passes from one seizure into another without regaining consciousness. This is rare, but is a medical emergency and professional medical help should be obtained. For more information on epilepsy, refer to chapter 4 of this manual.

The general principles of first aid for someone who is having a seizure are: 1) protect the individual from physical harm during the seizure, 2) protect the individual from embarrassment, 3) position the head, if possible, to assure an open airway (do not force the head back; you may try to turn the individual onto his stomach so that the jaw falls forward). Do not use a bite stick.

Record the details of the seizure; the following form may be useful for doing so.

NOTES:

SEIZURE REPORT

CLIENT'S NAME _____ DATE _____

TIME SEIZURE OCCURRED _____ PLACE _____

CHECK APPROPRIATE BLANKS	BEFORE SEIZURE	AFTER SEIZURE
1. Depressed		
2. Irritable		
3. Listless		
4. Apathetic		
5. Warning "Aura" stated by client including:		
a. restlessness		
b. unusual visual sensation		
c. unusual taste sensation		
d. unusual smell sensation		
e. unusual sound sensation		
f. headache		
6. Running or other activity		
7. Constipation		
8. Menstruation		
9. Variance in Medication		

- if checked, please explain _____

_____

_____

_____

10. Other _____ _____ _____

MOTOR INVOLVEMENT DURING SEIZURE	(check appropriate blanks)		
1. No abnormal involvement			
2. Fell to ground			
3. Repeated motor activity			
4. Muscular movement of body	right _____	left _____	both _____
5. Muscular movement of arms	right _____	left _____	both _____
6. Muscular movement of legs	right _____	left _____	both _____
7. Muscular movement of face			

CONSCIOUSNESS LEVEL	(check appropriate blanks)
1. Loss of consciousness during seizure	
2. Loss of awareness during seizure	
3. Confused during seizure	
4. Confused following seizure	
5. Resumed normal activity	
6. Slept following seizure	

APPROXIMATE LENGTH OF SEIZURE _____

COMMENTS _____

_____

_____

MEDICATION ADMINISTRATION REVIEW

ALL MEDICATIONS ARE POISONIOUS! It is necessary to maintain the correct dosage for beneficial results. Because of the nature of medication you should be knowledgeable about the particular types that you are administering. Valuable sources of information for such purposes are the parents, a pharmacist, physician or the Physician's Desk Reference.

Keep an honest record of all administered medications including times and dosages as well as any problems encountered.

REMEMBER THE FIVE "RIGHTS" OF MEDICATION ADMINISTRATION

RIGHT PATIENT
RIGHT DRUG
RIGHT DOSE
RIGHT TIME
RIGHT METHOD

The following is an example of a medication administration record. Also included is a medication glossary and common medication equivalents.

MEDICATION ADMINISTRATION RECORD

Client's Name _____ Dates From _____ To _____ Provider Name _____

Type of Medication or Treatment _____ Dose: _____

Date --				
Times -				

Comments: _____

* * * * * * * * * * *

Type of Medication or Treatment _____ Dose: _____

Date --				
Times -				

Comments: _____

* * * * * * * * * * *

Type of Medication or Treatment _____ Dose: _____

Date --				
Times -				

Comments: _____

* * * * * * * * * * *

MEDICATION GLOSSARY

1. AEROSOL - a medicine mixed with air for inhalation.
2. AMPULE - a small glass vial.
3. ANALGESIC - a medicine that is used to relieve pain (aspirin).
4. ANAPHYLACTIVE SHOCK - a state of collapse resulting from injection of a substance to which a body has become sensitized.
5. ANESTHETIC (general) - a medicine that produces total loss of consciousness and insensibility to pain (alcohol, ether).
6. ANESTHETIC (local) - a medicine that diminishes the sensibility of the part to which it is applied (camphor, cocaine).
7. ANOREXIA - a loss or lack of appetite.
8. ANTACIDS - neutralize acids in the stomach.
9. ANTHELMINTIC - a drug used in the treatment of worms.
10. ANTIBIOTIC - a chemical substance produced by microorganisms which has the capacity in dilute solutions to inhibit the growth of or to destroy bacteria and other microorganisms used largely in the treatment of infections and diseases.
11. ANTICONVULSANT - a medicine to prevent and control convulsions and seizures.
12. ANTIEMETIC - a medicine that stops vomiting.
13. ANTIPYRETIC - a medicine that decreases the body temperature and relieves fever.
14. ANTISPASMODICS - lessen contractions of muscles and also lessen convulsions.
15. BACTERICIDAL - refers to an agent that brings about death of bacteria.
16. CARDIAC DEPRESSANTS - reduce the heart action so that the heartbeats are slower and weaker.
17. CARDIAC STIMULANTS - increase the action of the heart so that the heartbeats are stronger and faster.
18. CATHARTICS - cause evacuation of the bowel.
19. CAUSTICS - burn or destroy tissues.
20. CEREBRAL DEPRESSANTS - lessen brain activity making the patient dull and less active, produces sleep in large doses.

21. CEREBRAL STIMULANTS - increase brain activity making the patient more active, more talkative, in large doses may produce delirium, hallucinations and convulsions.

22. CHEMOTHERAPY - the use of chemical agents in the treatment of disease; the chemical substance exerts a specific toxic effect on microorganisms rather than on the tissues of the patient.

23. DIURETIC - a drug that increases the quantity of urine secreted.

24. EMETIC - a substance that causes vomiting.

25. EXPECTORANT - a medicine that increases or modifies bronchial secretion.

26. FUNGICIDE - a substance that is able to destroy a fungus.

27. HYPNOTICS - produces sleep.

28. ICTERUS (jaundice) - deposit of bile pigments in the skin giving it a deep yellow color.

29. LAXATIVES - produce mild evacuation of the bowel.

30. NARCOTICS - drugs that produce sleep or stupor and also relieve pain.

31. PARENTERAL - refers to administration other than by mouth (needle).

32. PROPHYLACTIC - pertaining to the prevention of disease.

33. RESPIRATORY DEPRESSANT - a medicine that lowers the activity of the respiratory center and slows respirations; respiratory stimulants in toxic doses are respiratory depressants.

34. RESPIRATORY STIMULANT - a medicine that increases the activity of the respiratory center and accelerates respiration.

35. SEDATIVES - diminish the activity of an organ or part of all of the body. Usually are drugs to reduce nervous excitability.

36. SPASTICITY - a tendency to spasm or have violent contractions.

37. SYNTHETIC - made in a laboratory (artificially prepared).

38. UTICARIA - a condition of the skin characterized by wheals surrounded by a red area and associated with sensations of burning and itching commonly known as "hives".

COMMON MEDICATION EQUIVALENTS

1000 ml = 1 quart
30 ml = 1 fluid ounce
4 ml = 1 fluid dram
1 ml = 15 minums
30 gm = 1 ounce
15 gm = 4 drams
1 gm = 15 grains
60 mg = 1 grain
10 mg = 1/6 grain
1 mg = 1/60 grain
2 tbsp = 1 fluid ounce
1 tbsp = 1/2 fluid ounce
1 tsp = 5 cc
30 ml = 1 fluid ounce
1 cc = 15 drops

COMMON ABBREVIATIONS USED IN ADMINISTRATION OF MEDICATIONS

ad lib - as much as one pleases
aa, a.a. - of each
a.c. - before meals
b.i.d. - twice a day
cap., caps. - capsule, capsules
c., $\bar{c}$ - with
elix. - elixir
gel - a gel, jelly
Gm. - gram
gr. - grain
gtt - drop
h., hr. - hour
h.s. - at bedtime (hour of sleep)
noct. - night
o.d. - right eye
o.s. - left eye
o.u. - both eyes
per os., P.O. - by mouth
p.c. - after meals
p.r.n. - if necessary
q.n. - every hour
Rx, R. - take
q.i.d. - 4 times a day
q2h - every 2 hours
q3h - every 3 hours
q4h - every 4 hours
s.s., $\bar{ss}$ - one half
stat. - immediately
tab. - tablet
t.i.d. - 3 times a day
tr., tinc - tincture
ungt. - ointment
i, I - one
ii, II - two
iii, III - three
iv, IV - four
v, V - five
vi, VI - six
vii, VII - seven
viii, VIII - eight
ix, IX - nine
x, X - ten
ml - milliliter
cc - cubic centimeter
L., - liter
dr., ℥ - dram
oz., ℥ - ounce

DDTI

The Developmental Disabilities Training Institute is a non-profit corporation on contract with the Montana Developmental Disabilities Division. DDTI was created in order to provide a permanent system of orientation and training to both Title XX providers and the Developmental Disabilities Division. This operation is somewhat unique within systems of human services. DDTI proposes to directly support, through staff training, the development and maintenance of community-based programs.

Training is provided according to a competency-based format, identifying both a knowledge base and specific performance products which are necessary for the delivery of specialized services to the developmentally disabled. The basic goal of the Developmental Disabilities Training Institute is to develop and maintain a responsive system of information dissemination and training. The concept of DDTI as a provider allows it to expand or decrease its capabilities as the Division and needs throughout the state mandate. Systematic and consistent training is available in all portions of the state.

WHOM DOES THE DEVELOPMENTAL DISABILITIES TRAINING INSTITUTE SERVE?

Orientation and training services are available to the Developmental Disabilities Division staff, to Title XX Residential providers, and to Title XX Day Program providers. Examples of residential services include group homes, semi-independent living, and foster homes. Within day programs, this includes day activity, vocational centers, and other specialized day activities. The limitations imposed by federal training dollars that fund DDTI require that training is provided to those persons in a direct line service position.

DDTI TRAINING STAFF

The Developmental Disabilities Training Institute is composed of both a core staff and a regional staff. This staff has knowledge and skill in training staff of community-based services. This includes persons who have both the "hands-on" clinical training skills and those who have been directly involved in program development. The core staff is composed of a director, a residential training specialist and staff, a day program specialist and staff, a training design specialist, and an instructional materials specialist. In addition, each region has a regional clinical trainer whose primary functions include providing a needs assessment, and working directly with the Division staff and program providers in the delivery of staff training. Regional clinical trainers do not provide direct care, but rather assist in insuring that the staff have these "hands-on" skills.

TRAINING REQUESTS

Any questions, concerns or requests for training within a region should be channeled through the regional DD Division supervisor. While the Regional Clinical Trainer can assist in making these contracts, the DD Supervisor must participate in the establishment of a training contract. The state DD Division in Helena may also be contacted through Jan Frisch to establish state-wide training needs. Any questions or concerns should be directed to Carl F. Calkins, Director, DDTI, 508 Power Block, Helena, MT 59601. Phone: 443-4650.

BOARD MEMBERS

Since DDTI is a relatively new provider and is relying heavily upon input from the Division, providers, regional councils, and friends, the members of the

Board of Directors would like to be contacted for your input. Board members are located in each of the regions in the state and within several key organizations. They include:

Sam Sunwall	Box 78, Star Route, Conrad, MT 59425	627-3487
Lee Warren	Nashua, MT 59428	746-3277
Jerry Willis	1618 Choteau, Helena, MT 59601	442-4147
Peg Macdonald	3103 Stinson, Billings, MT 59101	656-3228
Art Kienas	147 Caroline Road, Kalispell, MT 59901	742-3590
Marshall Cook	Office of Higher Education 1231 11th Ave., Helena, MT 59601	449-3024
Warren Gardner	Northern Montana College, Havre, MT 59501	265-7821

notes